

FELONY OF THE THIRD DEGREE.

## Vision Plan Enrollment Form State of Wisconsin Retirees

To select vision care through Spectera, complete this form and mail before November 15th to: Benefit Systems Inc./Spectera, Attn: Spectera WI Retiree Vision, P.O. Box 80447 Indianapolis, IN 46280-0447; or FAX to (317) 573-2016; or visit the Web site at <a href="https://secure.benefit-systems.com/wiretire/">https://secure.benefit-systems.com/wiretire/</a>. You must reenroll in order to keep the coverage. *Please keep a copy of this form for your records.* 

I. Check the Appropriate Box The Rates Listed Below are for One Year					
Retiree Only	\$ <u>64.80</u>	Retiree -	+ Spouse	\$ <u>126.00</u>	
Retiree + Children	\$ <u>132.00</u>	Retiree	+ Family	\$ <u>198.00</u>	
II. Retiree Information (please print clearly):  Social Security Number					
Your Name	(First)	(Middle Initial)	(Last)	)	
Birth Date/					
Address					
Home Phone ()					
	ble Family Members	<u> </u>			
First Name	Last Name	e Bi	rth Date	Full Time Student?	Gender
Spouse		/	/	not applicable	□M / □F
Child			/	☐ Yes ☐ No	□M / □F
Child			/	☐ Yes ☐ No	$\square$ M / $\square$ F
Child			/	☐ Yes ☐ No	□M / □F
Child			/	☐ Yes ☐ No	□M / □F
IV. Payment Method:					
Visa ☐ MasterCard ☐ Discover ☐ Check ☐ (Make payable to Spectera)					
Account Number Expiration Date					
Signature					
I agree to continue enrollment in the vision plan for a period of 12 months and authorize you to charge my credit card, if indicated above, or deposit my check as payment in full for one year of vision care services. At this time, I will include my annual premium per the coverage level that I selected in Section 1 of this form knowing that if the subscriber terminates I must use the subscriber's date of birth and Social Security number for services. I know renewals for this coverage will be on a 12-month cycle and I cannot change family status or drop this coverage until the 12-month cycle expiration (December 1, 2005).					
Your Signature Date					

Spectera provides services under the following regulated subsidiaries in the following states: Spectera Vision Inc.; Maryland - Spectera Insurance Company

Florida Residents Only: NOTICE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A